Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NORTH TEXAS REHABILITATION CENTER
214 W COLORADO
DALLAS TX 75208-4514

Carrier's Austin Representative Box
Box Number 19

MFDR Date Received
December 6, 2010

Respondent Name
AMERICAN HOME ASSURANCE CO

MFDR Tracking Number
M4-11-1151-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The dates of service are 12-16-09, 12-17-09, 12-18-09, 12-24-09 and 12-28-09. Medical necessity was proven by the attached letter of the utilization Review Company, Health Direct. North Texas Rehabilitation Center is a CARF facility and in accordance with rules 134.202(e)(5) the insurance carrier was billed accordingly and to this date no payment has been made."

Amount in Dispute: $3,600.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Requestor billed $3,600.00 and the Carrier did not make any reimbursement as this treatment has been deemed unnecessary prior to the rendered services by a peer review physician, Juan Capello, M.D."

Response Submitted by: Chartis, 4100 Alpha Road, Suite 700, Dallas, TX 75244

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 16, 2009	97545-WH-CA x 1 unit/hour 97546-WH-CA x 2 units/hours	$200.00 $200.00	$0.00 $0.00
December 17, 2009	97545-WH-CA x 1 unit/hours 97546-WH-CA x 6 units/hours	$200.00 $600.00	$0.00 $0.00
December 18, 2009	97545-WH-CA x 1 unit/hours 97546-WH-CA x 6 units/hours	$200.00 $600.00	$0.00 $0.00
December 24, 2009	97545-WH-CA x 1 unit/hours 97546-WH-CA x 6 units/hours	$200.00 $600.00	$0.00 $0.00
December 28, 2009	97545-WH-CA x 1 unit/hours 97546-WH-CA x 6 units/hours	$200.00 $600.00	$0.00 $0.00
TOTAL		$2,800.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting an Independent Review Organization (IRO).
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated January 7, 2010
   - 1 – (216) – Based on the findings of a review organization.
   - 2 – (W1) – Workers Compensation State Fee Schedule Adjustment

   Explanation of benefits dated January 13, 2010
   - 1 – (216) – Based on the findings of a review organization.
   - 2 – (W1) – Workers Compensation State Fee Schedule Adjustment

   Explanation of benefits dated January 15, 2010
   - 1 – (216) – Based on the findings of a review organization.
   - 2 – (W1) – Workers Compensation State Fee Schedule Adjustment

   Explanation of benefits dated January 19, 2010
   - 1 – (216) – Based on the findings of a review organization.
   - 2 – (W1) – Workers Compensation State Fee Schedule Adjustment

   Explanation of benefits dated April 2, 2010
   - 1 – (216) – Based on the findings of a review organization.
   - 2 – (W1) – Workers Compensation State Fee Schedule Adjustment

   Explanation of benefits dated April 14, 2010
   - 1 – (216) – Based on the findings of a review organization.
   - 2 – (W1) – Workers Compensation State Fee Schedule Adjustment
   - *Our position remains the same if you disagree with our decision please contact the TWCC Medical Dispute Resolution. (X394)

   Explanation of benefits dated April 15, 2010
   - 1 – (216) – Based on the findings of a review organization.
   - 2 – (W1) – Workers Compensation State Fee Schedule Adjustment
   - *Our position remains the same if you disagree with our decision please contact the TWCC Medical Dispute Resolution. (X394)

Issues

1. Is the respondent's denial reason code '216' supported? Did the requestor file for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Is the requestor eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. The requestor filed a dispute with the Medical Fee Dispute Resolution section at the Division on December 6, 2010. The respondent denied the disputed services based on "216 – Based on the findings of the review organization." According to 28 Texas Administrative Code §133.305(a)(4), a medical fee dispute is a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) goes on to state that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this

subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. No documentation was submitted to support that the issue(s) of medical necessity have been resolved as of the undersigned date for the services rendered on December 16, 2009 through December 28, 2009. The Division finds that the respondent's denial reason of "216" has been supported.

Texas Labor Code, Section §413.011(b) "the insurance carrier is not liable for those specified treatment and services unless preauthorization is sought by the claimant or health care provider and either obtained from the insurance carrier or order by the commission." 28 Texas Administrative Code, Section §134.600(c)(1)(B) states, "The carrier is liable for all reasonable and necessary medical costs relating to the health care required to treat a compensable injury…only when the following situations occur…preauthorization of any heath health care listed in subsection (p) of this section was approved prior to providing the health care." 28 Texas Administrative Code, Section §134.600(p)(4) requires preauthorization of "all non-exempted work hardening or non-exempted work conditioning programs." Review of the submitted documentation finds that the requestor obtained preauthorization approval under number 055158602 on January 7, 2010 for 7 additional sessions of work hardening with a start date of January 6, 2010 and an end date of April 7, 2010. Further review of the submitted documentation finds that the disputed dates of service were rendered and billed prior to the preauthorized timeframe.

2. The requestor has failed to support that the services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning medical necessity have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 413 prior to the submission of a medical fee dispute for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 28, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.